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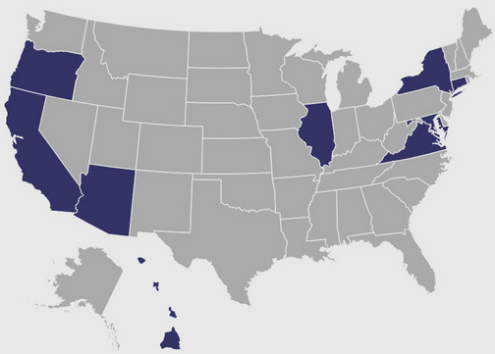
The Effects of Prohibitions Associated with Mental Illness

Federal law prohibits the possession or purchase of firearms by certain individuals who have been adjudicated as mentally ill (18 U.S.C. 922).[1] The number of people covered by that exclusion is not known. An estimated 44 million adults in the United States have some form of *mental illness*, defined as any "diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder" (Substance Abuse and Mental Health Services Administration, 2016). Of these adults, approximately 10 million suffer from a "serious mental illness" that results in substantial impairment in carrying out major life activities. Existing laws that prohibit those with mental health conditions from accessing firearms affect a subset of individuals who likely fall into the "serious mental illness" category. Expanding such prohibitions has the potential to affect a much larger subset of individuals who fall within the "any mental illness" category, although broadening the scope of mental health restrictions poses technological, coordination, and legal (i.e., privacy) challenges (Liu et al., 2013).

MORE ABOUT THE POLICY

States with This Type of Law



States with expanded mental health–related prohibitions

If individuals with mental illness present a higher violence risk to themselves or others compared with those without mental illness, then restricting their access to firearms should reduce suicides or homicides. The magnitude of these effects will depend primarily on the reliability of the screening process instituted to identify disqualifying mental health conditions, the size of the marginal population affected by the expanded prohibitions, and the likelihood of individuals in that population committing harm to others or to themselves.

Map data are valid as of January 1, 2017.

MORE ON STATE IMPLEMENTATION

Epidemiological evidence suggests that a diagnosis of mental illness alone has little relation to risk of interpersonal violence (Swanson et al., 2015); in particular, studies estimate that between 2 percent and 4 percent of all violent behavior may be attributable to mental illness (Corrigan and Watson, 2005; Swanson, 1994). One study found that among a sample of convicted murderers in Indiana, perpetrators with serious mental illness were significantly less likely to have used a firearm compared with other perpetrators (Matejkowski et al., 2014). A study of 82,000 individuals with mental illness in Florida showed that the arrest rate for violent crimes involving a firearm was the same among the study population as the estimated general population rate—approximately 215 arrests per 100,000 people (Swanson et al., 2016). Elevated rates of violence tend to be reported for involuntarily committed patients (Choe, Teplin, and Abram, 2008), but this population is already barred from acquiring firearms through existing federal mental health–related prohibitions. Overall, between 2001 and 2010, less than 5 percent of the 120,000 firearm-related homicides in the United States were committed by individuals diagnosed with a mental illness (Metzl and MacLeish, 2015), suggesting that expanded prohibitions based on mental health status may not have a large effect on firearm crimes.

Although media coverage often links mass shootings with serious mental illness (McGinty et al., 2014), an analysis of 133 mass shooting events between 2009 and 2015 (Everytown for Gun Safety Support Fund, 2017b) reported that in only one incident (0.8 percent) did the perpetrator have a history of mental illness that prohibited purchase of a firearm from a federally licensed dealer; however, formal concerns about the mental health of the perpetrator had been previously expressed for 15 cases (11.3 percent), and informal concerns about the shooter's mental health had been previously expressed for 13 additional cases (9.8 percent). Although public mass shooters are more likely to have a psychotic disorder compared with perpetrators of multiple-victim shootings related to familicide or profit-motivation, the prevalence of severe mental illness among this subgroup is still quite low (Fox and Levin, 2015). Counting less-severe forms of mental illness, Follman, Aronsen, and Pan (2017) found that 50 of the 90 public mass shootings between 1982 and 2017 that were identified by *Mother Jones* magazine involved a shooter with a history of possible mental health problems.

At the same time, research indicates that individuals with mental disorders are more likely to be victims than perpetrators of violence (Desmarais et al., 2014). One study of persons with severe mental illness (in treatment at mental health agencies in Chicago) found that their annual exposure to violent crime victimization was more than four times higher than rates in the general population (Teplin et al., 2005). Another meta-analysis produced similar results, finding the prevalence of violent victimization among individuals with mental illness to be 24 percent (with estimates of the reviewed studies ranging from 7 percent to 63 percent) (Hughes et al., 2012). Extrapolating this estimate to the national population of individuals with serious mental illness in 2015 would suggest that approximately 2.3 million individuals with serious mental

illness are victims of violent crime each year; however, this is likely an overestimate because most studies sampled individuals who were receiving
inpatient or outpatient treatment for diagnosed psychiatric illnesses or focused on severe mental illnesses (such as schizophrenia) (Hughes et al., 2012). For instance, while the National Crime Victimization Survey (NCVS) does not collect information on mental health directly, NCVS estimates suggest that there are about 780,000 cases annually of violent crime against individuals with cognitive disabilities (defined as serious difficulty in concentrating, remembering, or making decisions because of a physical, mental, or emotional condition) (Harrell, 2017). Therefore, expanding the class of prohibited possessors to include more people with severe mental illness may lead to additional victimization because those people have reduced opportunities for defensive gun use. At the same time, such an expansion may decrease violent crime, mass shootings, and suicides carried out by this population.

Indeed, evidence supports that expanding prohibitions associated with mental illness may have larger effects in reducing rates of firearm suicides. Research has demonstrated a strong link between mental illness and suicide; it is estimated that between 47 percent and 74 percent of suicides are attributed to mental disorders (Li et al., 2011; Cavanagh et al., 2003). A study of 82,000 individuals with mental illness in Florida found that suicide was nearly four times as prevalent among this subpopulation compared with the general population, but firearms were half as likely to be used as a means of suicide; in more than 70 percent of these firearm suicide cases, the individual's mental health condition did not prohibit him or her from obtaining a firearm legally (Swanson et al., 2016).

To assess the effects of expanded mental health–related prohibitions, the ideal data would distinguish outcomes between those who are affected by the expanded prohibitions and those who are not. This type of analysis would necessitate a detailed database containing rich information on the mental health conditions of perpetrators of crime or victims of suicide. Because an individual's medical records are private, it may be particularly difficult to identify firearm-involved crime incidents in which the perpetrator was a prohibited possessor because of mental illness. Given these data challenges, as well as wide variation across states in mental health disqualifiers and inconsistencies in reporting, it is not surprising that we identified no studies meeting our inclusion criteria that estimated the effects of expanded prohibitions associated with mental illness. Nevertheless, three studies reviewed in our analysis of background checks examined the effect of implementing the Brady Handgun Violence Prevention Act (the Brady Act) checks on certain mentally ill people. Implementation of this law had the effect of expanding the class of mentally ill people who could not purchase a firearm, so we review those studies as well.

OUTCOMES THAT MAY BE INCREASED BY PROHIBITIONS

ASSOCIATED WITH MENTAL ILLNESS

We found no qualifying studies showing that prohibitions associated with mental illness increased any of the eight outcomes we investigated.

OUTCOMES THAT MAY BE DECREASED BY PROHIBITIONS ASSOCIATED WITH MENTAL ILLNESS

Suicide

There is limited evidence that prohibiting gun ownership by individuals with some types of mental illness histories may reduce total suicides and firearm suicides.

Violent Crime

Evidence that mental health–related prohibitions on gun ownership reduce violent crime is moderate. Evidence that these prohibitions reduce total homicide rates is limited. Evidence for the effect of such prohibitions on firearm homicides is inconclusive.

OUTCOMES WITH INCONCLUSIVE EVIDENCE FOR THE EFFECT OF PROHIBITIONS ASSOCIATED WITH MENTAL ILLNESS

We found no qualifying studies showing inconclusive evidence about prohibitions associated with mental illness.

OUTCOMES WITH NO STUDIES THAT MET OUR INCLUSION CRITERIA

- Defensive gun use
- Gun industry outcomes
- Hunting and recreation
- Mass shootings
- Officer-involved shootings

- Unintentional injuries and deaths

Review the inclusion criteria and methodology »

Notes

1. The Gun Control Act of 1968 prohibited the sale of firearms to any person who has been "adjudicated as a mental defective or has been committed to any mental institution" (Pub. L. 90-618).

2. For example, Alabama prohibits "anyone of unsound mind" from owning, possessing, or controlling a firearm and defines *unsound mind* as anyone

> (1) Found by a court, board, commission, or other lawful authority that, as a result of marked subnormal intelligence, mental illness, incompetency, condition, or disease, is a danger to himself or herself or others or lacks the mental capacity to contract or manage his or her own affairs; . . . [or] (3) Involuntarily committed for a final commitment for inpatient treatment to the Department of Mental Health or a Veterans' Administration hospital by a court after a hearing. (Ala. Code Åò 13A-11-72)

Alabama also includes individuals who have been "found to be insane, [found to be] not guilty by reason of mental disease or defect, found mentally incompetent to stand trial, or found not guilty by reason of a lack of mental responsibility." The Center to Prevent Gun Violence considers these restrictions separately, and we agree.

3. Alabama, Arkansas, California, Florida, Nevada, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Virginia, West Virginia, and Wyoming. See Ala. Code § 13A-11-72; Ark. Code Ann. § 5-73-103; Calif. Welf. and Inst. Code §§ 8100, 8103; Fla. Stat. Ann. § 790.065; Nev. Rev. Stat. Ann. § 202.360; N.Y. Penal Law §§ 265.00, 400, N.Y. Mental Hygiene Law § 9.46; Ohio Rev. Code Ann § 2923.13; Ore. Rev. Stat. Ann. §§ 166.250, 426.130; 18 Pa. Cons. Stat. § 6105; R.I. Gen. Laws. § 11-47-6; S.C. Ann. Code § 23-31-1040; Utah Code Ann. § 76-10-503; Va. Ann. Code § 18.2-308.1:2; W. Va. Ann. Code § 61-7-7; Wyo. Stat. Ann. § 6-8-404.

4. Arizona, Connecticut, Delaware, Hawaii, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Jersey, North Dakota, Washington, Wisconsin, and the District of Columbia. See Ariz. Rev. Stat Ann. §§ 13-3101, 13-3102, 36-540; Conn. Gen. Stat. § 53a-217; Del. Code Ann. Tit. 11 § 1448; Hawaii Rev. Stat. Ann. § 134-7; Kan. Stat. Ann. §§ 21-6301, 59-2946; Me. Rev. Stat. Ann. § 393; Md. Ann. Code § 5-133; Mass. Gen. Laws Ann. § 129B; Minn. Stat. Ann. § 624.713; N.J. Stat. Ann. § 2C:39-7; N.D. Cent. Code § 62.1-02-01; Wash. Rev. Code § 941.040; Wisc. Stat. §§ 941.29, 51.20, 54.10; D.C. Ann. Code § 7-2502.03.

5. Mo. Stat. Ann. § 571.070.

6. Mich. Comp. Laws. Ann. § 28.422; N.C. Gen. Stat. Ann. § 140-402. Furthermore, in Michigan, the prohibition applies only to those committed to psychiatric institutions.

7. Okla. Stat. Ann. § 1289.10; Tenn. Code Ann. § 39-17-1316.

8. Calif. Welf. and Inst. Code § 8100 (while voluntarily in treatment for being a threat to themselves or others); Conn. Gen. Stat. Ann. § 53a-217 (admitted within previous six months); 430 Ill. Comp. Stat 65/1.1, 65/8 (admitted within past five years), 405 Ill. Comp. Stat. 5/6-103.1; Md. Ann. Code § 5-133 (admitted for more than 30 consecutive days); D.C. Code Ann. § 7-2502.03 (admitted within past five years).

9. In Hawaii, possession is prohibited by those "diagnosed as having a significant behavioral, emotional, or mental disorder" (Hawaii Rev. Stat. Ann. § 134-7). California has a long list of disqualifiers, including threats of physical violence, various lengths of detention, and court-ordered evaluation and counseling (Calif. Welf. and Inst. Code §§ 8100, 8103, 5200-5213). Maryland restricts possession from any person who "suffers from a mental disorder . . . and has a history of violent behavior against the person or another" (Md. Ann. Code § 5-133), and Illinois and Connecticut restrict possession from those who threaten violence or demonstrate threatening behavior (430 Ill. Comp. Stat 65/1.1; Conn. Gen. Stat. Ann. § 53a-217).

10. Ariz. Rev. Stat §§ 36-540(A)(1), 13-3101(A)(7); Ore. Rev. Stat. §§ 166.250(1)(c)(D), 426.133; 18 Pa. Cons. Stat. § 6105; Va. Code. Ann. § 18.2-308.1:3(A). ⤴

11. N.Y. Penal Law § 400.001(1), N.Y. Ment. Hyg. Law § 9.27. ⤴

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